Responding to Children's Trauma: What Schools Are Doing

Thesis

Presented in Partial Fulfillment of the Requirements for the Bachelor of Science in Social Work in the College of Social Work at The Ohio State University

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Abstract

Introduction/Background: In the United States, somewhere between 25 and 80 percent of children experience at least one traumatic event before they reach adulthood. The effects of such experiences are well documented in the literature and can include physical, psychological, neurological, and behavioral implications. Trauma informed care involves the practices implemented by a variety of youth serving systems to address and mitigate the influence of trauma on children, and the benefits of these practices are well documented. In schools, trauma informed practices have been shown to improve student behaviors, academic performance, emotional well-being, and suspension rates, as well as improve teacher satisfaction and stress levels. There are a wide range of specific trauma informed programs available to schools, but there is a gap in the literature of the common types of trauma informed policies and practices and how often they are used in schools.

Methods: This study sought to fill this gap in the research through the use of a qualitative electronic survey sent to Ohio State University social work students who are placed in a school setting for their field placement. The survey was used to discover common behavior management strategies and trauma informed policies that are implemented in schools and common efforts schools take to promote the success of their students who have experienced trauma.

Results: This study found that 54% of participants reported that their school uses trauma informed care. From the responses of these participants, seven common elements of trauma informed care were identified including, the understanding that trauma contributes to behavioral issues, the use of specific trauma informed programs, referring students to a mental health professional, teacher and staff trainings, support from administration, crisis management staff, and students feeling emotionally supported.

Conclusions: This study found seven common elements of trauma informed care that are used by schools. This is significant as it fills the gap in the literature about this topic and contributes to the scientific knowledge about the use of trauma informed care in schools. Going forward more research should be completed about this topic to ensure that youth with trauma are receiving the services they need from their schools to be successful and have a positive well-being.

Dedication

I dedicate this thesis to the educators, school social workers, guidance counselors, administrators, and other staff members who make the effort everyday to help their students with trauma and advocate for the implementation of trauma informed care. Without these professionals' hard work and dedication, their students, communities, and the educational system would be much worse off.

Acknowledgements

I would like to thank my faculty advisor Kathryn Maguire-Jack for her guidance and support during the planning and facilitation of this project. I would also like to thank the College of Social Work for the opportunity and funding to engage in this research thesis. Finally, I would like to thank my honors cohort for their unconditional support throughout this process.

Curriculum Vitae

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Fields of Study

Major Field: Social Work

Minor Fields: Youth Development and Dance

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Chapter 1: Statement of Research Topic

Introduction

Exposure to traumatic events during childhood is a pervasive issue in our society. According to the existing literature, between 25 and 80 percent of youth in the U.S. experience at least one traumatic event during childhood (Costello et al., 2002; Finkelhor, Turner, & Ormrod, 2009a). The Substance Abuse and Mental Health Services Administration (2014) defines trauma as,

> an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (p. 7).

Youth may experience a wide range of experiences that are potentially traumatic, some examples include witnessing or experiencing physical or sexual abuse, domestic violence, natural disasters, car crashes, potentially fatal illnesses and diseases, or community violence (Swick, Knopf, Williams, and Fields, 2013).

The consequences of exposure to trauma in childhood can affect many areas of a child's life and development. Trauma may have detrimental impacts on a child's physical, neurological, and psychological development, as well as their behavior (Ko et al., 2008; Holmes et al., 2015; Swick et al., 2013). These effects are often long lasting and may even continue into adulthood (Perry, 2009).

In response to the prevalence and effects of childhood trauma, youth serving organizations and systems may implement trauma informed care. SAMHSA (2014) describes trauma informed care as an approach that,

> realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization (p. 9).

Trauma informed care is utilized in a variety of youth serving systems, including the health, juvenile justice, child welfare, and educational systems, to reduce the negative effects of trauma and improve a child's wellbeing (Ko et al., 2015). Trauma informed care within the educational system has increasingly become a larger focus of childhood trauma research because of the educational system's daily access to children who have experienced trauma and schools' abilities to provide consistent environments for such children (Holmes, Levy, Smith, Pinne, & Neese, 2015; Walkey & Cox, 2013). The benefits of trauma informed schools and classrooms are well documented and can include improved student behavior, academic performance, school climate, and teacher satisfaction and decreases in suspensions and expulsions (Crosby, 2015; Martin et al., 2017).

There are a variety of evidence-based trauma informed programs available to schools, including Child-Adult Relationship Enhancement (CARE), Positive Behavioral Interventions and Support (PBIS), and CAPPD (Gurwitch, 2016; Farrell, Collier-Meek, and Pons, 2013; Walkley & Cox, 2013; Perry, 2009).The current study aims to fill a gap in the literature of the common types of trauma informed practices utilized in schools and the rate at which they are implemented.

Statement of the Problem

Prevalence of Childhood Trauma

The prevalence of childhood exposure to trauma has been extensively researched. Costello et al. (2002) found that 25 percent of study participants had been exposed to at least one of what they determined to be a "high magnitude event" before the age of 16 (p.100). These events were those deemed to be serious enough to likely result in the development of Post-Traumatic Stress Disorder, such as having experienced or witnessed a death, serious injury, or threat of death (Costello et al., 2002). The original study of Adverse Childhood Experiences (ACEs) determined that over 50 percent of its participants reported experiencing at least one of these adverse experiences during their childhood or adolescence (Felitti et al., 1998). The ACEs that were measured in this study were physical, psychological, or sexual abuse, and household mental illness, substance abuse, violence against mother, or criminal behavior (Felitti et al., 1998). A more recent study discovered that over 60 percent of the youth in a national sample had experienced or witnessed at least one act of direct victimization, including a wide range of violence such as physical or sexual assault, maltreatment, property victimization, and other forms, in the year prior to the study (Finkelhor, Turner, Ormrod & Hamby, 2009b). A study using the same national data set to explore childhood exposure to multiple forms of victimization across the lifetime found that 80 percent of participants were exposed to one or more forms of victimization in their lives (Finkelhor, Turner, & Ormrod, 2009a).

There is also a high rate of youth experiencing or witnessing multiple traumatic events throughout their lifetime. In the Felitti et al. (1998) ACEs study, 25 percent of respondents reported experiencing two or more adverse childhood experiences, and 6.2 percent reported exposure to four or more. Finkelhor et al. (2009b) found that 38.7 percent of participants had

been exposed to two or more victimizations, 10.9 percent reported five or more, and 2.4 percent had ten or more exposures to direct victimization in the year of the study. Studying the rate of exposure to different types of victimization, Finkelhor et al. (2009a) reported that 66 percent of participants had experienced more than one type, 30 percent had five or more types, and 10 percent had exposure to 11 or more types of victimization.

Effects of childhood trauma

The consequences of exposure to childhood trauma and stress are well documented across the literature. Trauma and chronic stress during childhood are associated with long lasting impairments to physical, neurological, and psychological development, as well as a range of behavioral effects. Across categories of development and functioning, the effects of trauma tend to increase with the number of exposures to traumatic events (Turner, Finkelhor, and Ormrod, 2009a; Connell, Pittenger, and Lang, 2018). In addition, the effects of childhood trauma can be long lasting, potentially continuing throughout adulthood, so it is crucial that youth who have experienced trauma receive treatment as soon as possible to reduce the chance of long-term consequences (Perry, 2009).

Physical

The purpose of the Felitti et al. (1998) study was to explore the relationship between adverse childhood experiences and health behaviors and diseases later in life. They found a correlation between the number of ACEs experienced during childhood and the amount of risky health behaviors and diseases present in adulthood (Felitti et al., 1998). Respondents who reported exposure to at least four ACEs during childhood were 4-12 times more likely to experience substance abuse, depression, and attempt suicide; 2-4 times more likely to smoke,

rate their health quality as poor, have more than 50 different sex partners, and have an STD; and 1.4-1.6 times more likely to be physically inactive and obese (Felitti et al., 1998). The number of ACEs reported by respondents was also linked to the likelihood of developing of many diseases including heart disease and cancer, which are leading causes of death in adults, as well as chronic bronchitis, hepatitis, and broken bones (Felitti et al., 1998). Further research has also linked exposure to ACEs to increased risk of asthma, stroke, heart attack, and diabetes (Centers for Disease Control, 2015).

Neurological

Cross, Fani, Powers, and Bradley (2017) reviewed the literature on the effects of trauma and chronic stress exposure on the neurobiological development of children. The research shows that certain areas of the brain, including the hippocampus, prefrontal cortex, and amygdala can be physically altered after exposure to trauma and stress in childhood, which can result in changes to emotional and cognitive functioning (Cross et al., 2017). Cross et al. (2017) focused their review around three such functions, including executive functioning, emotional regulation, and interoceptive awareness, which can be impaired by childhood exposure to trauma, especially when it happens frequently and early in life.

Psychological

The psychological and emotional effects of childhood trauma are well established. Adults who experienced four or more ACEs are more likely to struggle with substance abuse, depression, and suicidal ideation and attempts than peers (Felitti et al., 1998). A study by Johnson (2017) also found that experiencing childhood trauma is associated with increased risk of suicidal ideation, specifically for youth involved in the justice system. Individuals who were

exposed to childhood trauma are also more likely to be diagnosed with post-traumatic stress disorder (Read and Mayne, 2017). Childhood trauma is also associated with comorbid psychiatric problems including substance abuse, depressive disorders, mood disorders, PTSD, anxiety disorders, aggression, and more (Dye, 2018). Read and Mayne (2017) state that only considering negative psychological effects purely in the context of formal psychiatric diagnoses such as PTSD does not portray the full picture of the psychological damage related to trauma, as even children who do not meet the criteria for this diagnosis may still suffer from some of its symptoms, disrupting normal functioning.

Behavioral

There are various behavioral issues that are also associated with childhood trauma. Mckelvey, Edge, Mesman, Whiteside-Mansell, & Bradley (2018) found that exposure to ACEs in infancy and toddlerhood is connected to increased rates of being held back a grade at school, externalizing and internalizing behavior problems, and attention problems. The study by Read and Mayne (2017) supports previous research that adverse experiences in childhood are predictive of a wide array of negative outcomes, "including not only a range of specific behaviors and feelings, but global functioning and risk to self and others" (p.294). Holt, Finkelhor, and Kantor (2007) also found that youth with multiple victimizations had lower grades and more behavioral issues in school. In addition, youth who have experienced trauma are also likely to have decreased social skills, less school engagement, lower grade point averages, decreased rate of graduation, lower test scores, and are more likely to be suspended or expelled from school than their peers who have not experienced trauma (Crosby, 2015).

Purpose of the Study

The purpose of this study is to fill the gap in the literature about the trauma informed practices most commonly used in schools and how often they are used. Specifically, this study will explore the common trauma informed practices used in trauma informed schools, as well as the common types of behavior management strategies used in all schools. This study seeks to contribute to the scientific literature by providing further data about the use of trauma informed care in the educational system. The information gathered in this study, in addition to information from other studies, could be used to inform future research to improve the educational system to better serve and promote the wellbeing of students with trauma histories.

This study will utilize a qualitative approach to explore the subject of trauma informed policies and practices utilized in school settings. Rich and detail descriptions of these practices and policies will be obtained through the use of an electronic survey sent to students in The Ohio State University Master of Social Work program who are placed in a school for their field practicum. The participants' descriptions of their schools' disciplinary policies and practices will be used to identify the types of trauma informed practices that are used in schools. This will be completed by finding common language, policies, and practices among the answers of the participants. For the schools that have trauma informed educational policies and practices in place, these policies will be explored. For schools that do not currently have a trauma informed approach, barriers that prevent the implementation of trauma informed practices will be investigated.

Research Question

The research question this study aims to answer is: How do schools use trauma informed techniques and strategies to manage students' trauma related behaviors and promote student well-being? The specific aims of this study are: (1) To identify the behavior management

strategies and practices that are commonly used by schools, (2) To identify the trauma informed policies that are implemented in schools, and (3) To identify the efforts taken by schools to promote the success of youth with trauma related behavioral issues.

Chapter 2: Literature Review

Trauma Informed Care

Childhood trauma is an extensive problem that affects the lives of many youth in our country. The symptoms and consequences of experiencing a traumatic event during childhood can be serious and persistent throughout life. In response to the effects of trauma, youth serving systems may choose to implement trauma informed care to better serve the youth with whom they work.

Trauma informed care involves the practices utilized by child-serving systems and service providers to address the influence trauma has on children and their families (Ko et al., 2015). There is no fixed set of practices under the name trauma informed care, and Ko et al. (2015) asserts that "each child-serving system approaches trauma differently; has different levels of awareness, knowledge, and skill about trauma" (p. 397). Trauma informed care is utilized by a wide range of systems that work with youth, including the child welfare, healthcare, education, juvenile justice, first responder, and other systems (Ko et al., 2015).

Schools have been the focus of much of the recent trauma informed literature because educators are in an ideal position to combat the effects of childhood trauma. Teachers and other school staff members interact with youth daily and can provide the safe, consistent, and caring environments that children with trauma need to be successful (Holmes, Levy, Smith, Pinne, & Neese, 2015; Walkey & Cox, 2013). Schools that implement trauma informed care generally see many benefits of their efforts. These benefits can include improved student behavior and academic performance, school climate, and teacher satisfaction, as well as reductions in stress of

students and teachers and the use of special education services (Crosby, 2015). According to Martin et al. (2017) these benefits can also include,

> decreases in children's symptoms of trauma, PTSD, anxiety, and avoidant coping strategies; improvement in children's emotion regulation, social academic competence, classroom behavior, and discipline; improvement in students' grades, test scores and graduation rates; and decreases in students' suspensions and expulsion (p. 961).

There are a wide range of trauma informed programs, curriculums, and guidelines that are currently available to schools. Several specific trauma informed practices that are used in schools are simply guidelines that staff members can apply to the interactions they have with students (Gurwitch et al., 2016).

One such program, Child-Adult Relationship Enhancement (CARE), provides a set of skills for adults to employ in their interactions with youth (Gurwitch, 2016). These skills include for adults to "quash the need to lead, quit unnecessary questions, quiet the criticisms, praise, paraphrase, point out" (p. 141). These guidelines allow for the interaction to be led by the student and foster connection and engagement between the adult and child (Gurwitch, 2016).

Another program, created by the trauma informed training initiative Multiplying Connections gives educators guidelines for how to create a physically and emotionally safe environment for students (Walkley & Cox, 2013; Perry, 2009). The program is titled CAPPD, which stands for calm, attuned, present, predictable, and don't let children's emotions escalate yours, which inform adults interactions with youth (Walkley & Cox, 2013; Perry, 2009). These trauma informed practices are used to enhance adult child relationships and manage behavior issues (Walkley & Cox, 2013).

Positive Behavioral Interventions and Support (PBIS) is another form of behavior management that gives an array of techniques for modifying student behavior and focuses on school climate, strategies to prevent undesired behaviors, and system wide practices (Farrell, Collier-Meek, and Pons, 2013). PBIS provides "systematic procedures for teaching and rewarding students for desired behaviors" (Farrell et al., 2013, p. 39). With PBIS, teachers teach the desired behavior, give examples and demonstrations, and give students opportunities to practice the behavior while offering systematic praise (Farrell et al.2013). These practices should be school wide and consistent across all school contexts to be effective (Farrell et al., 2013). Fecser (2015) reviewed the literature and compiled a list of evidence-based trauma informed strategies for creating safe classroom environments, managing oppositional behaviors, and strengthening the teacher-student relationship. A common element among various trauma informed programs and guidelines is the importance of the relationship between the teacher and student (Fecser, 2015).

Although there is scientific literature available about these trauma informed practices and programs, there is little research available about how often they are used and which are commonly utilized in schools. This study aims to fill this gap in the literature about the common ways that trauma informed care is used in schools with the use of an online qualitative survey completed by school social work students about the school where they are completing their field placement.

Chapter 3: Methodology

The research question and specific aims of this study were stated in Chapter 1, in addition to an overview of the research design and methodology. This chapter will provide more detail about the research methods, including the study design, sample, data collection procedures, measures, and data analysis. As stated in Chapter 1, this study aimed to answer the research question, how do schools use trauma informed techniques and strategies to manage students' trauma related behaviors and promote student well-being? The specific aims targeted by this study included, (1) to identify the behavior management strategies and practices that are commonly used by schools, (2) to identify the trauma informed policies that are implemented in schools, and (3) to identify the efforts taken by schools to promote the success of youth with trauma related behavioral issues.

Research Design

This study utilized an online survey with a mainly qualitative approach with some quantitative components. The research question being investigated is exploratory in nature, aimed at exploring the subject of trauma informed practices used in schools. It was decided that this topic would best be investigated with the acquisition of rich and detailed descriptions of schools' practices, along with a few quantitative questions about the frequency of use of certain practices and to find answers to close-ended questions, such as "does your school have trauma informed policies?" As the number of quantitative questions were very few, this study is being considered a qualitative study rather than mixed methods.

The use of mainly open-ended, qualitative questions prompted participants to describe their school and its practices exactly as they are, allowing for more accurate descriptions than if they were to choose from preset responses created by the researcher in multiple choice questions.

In addition, as this study is exploratory in nature, the use of open-ended, qualitative questions granted a deeper exploration of trauma informed care than if the survey were to have asked participants to respond to solely close-ended questions. The use of qualitative questions also allowed for participants to respond to questions as they interpreted them, allowing for increased levels of variation and diversity in the responses and data. Overall, the use of a mainly qualitative approach ensured that data that was collected explored the research topic and gave accurate depictions of schools' trauma informed and behavior management practices.

The few quantitative components of this study allowed for the collection of details to supplement the qualitative data also collected in the survey. These questions provided background knowledge about the participant, their school, and their policies and practices. This allowed for the creation of skip logics in the survey which asked a different set of questions to participants who reported that their school was trauma informed and those who reported their school was not. In addition, the quantitative questions also provided a break for the participants from responding to the many qualitative questions in the survey, likely increasing the rate of survey completion.

Sample

The online survey for this study was sent to Ohio State University Master of Social Work (MSW) students on the school social work track. The inclusion criteria for this study included that participants were currently completing the field education component of their master's degree in a school setting, which could include a school, multiple schools across a school district, or a mental health agency contracted into a school. The study included all such students regardless of where their placement school is located, what type of school it is, what age range of students it serves, or whether it is trauma informed. This population was chosen as opposed to

professionals employed by schools in order to increase the likelihood of participation and the ease of recruiting potential participants, as it was decided college students would be more likely to fill out the survey and they could easily be recruited through the College of Social Work. An email was sent to the Ohio State MSW school social work list-serv, which was obtained through the Ohio State MSW Office of Field Education to recruit potential participants. This email is listed in Appendix A. Participants received a $5 Starbucks gift card following the completion of the survey as an incentive for participation. A total of 24 participants completed the survey and received the incentive.

As this study involves human participants, the researcher obtained approval from the Ohio State University Institutional Review Board prior to conducting any research. This study received an official endorsement from the IRB, recognizing the ethical considerations and minimization of risks to participants.

Data Collection Procedures

An electronic survey in the online system Qualtrics was created to collect data for this study. This survey included mostly qualitative questions, with some quantitative, about the school where the participant is completing their field placement, including questions about the schools' demographics, trauma informed practices, behavior management strategies, and efforts taken to promote the success and wellbeing of students with trauma histories. An online survey was chosen as the data collection method for this study as it allowed for a larger sample size and was more time and cost effective than other forms of qualitative research such as interviews or focus groups. It was decided that these benefits of electronic surveys outweighed the potential limitations, such as email invitations to participate getting lost in potential participants' inboxes, short and nondetailed responses, and a less rich understanding of the research topic than if

interviews were used as the data collection method. These potential limitations were mitigated by sending a reminder email following the initial invitation and including a variety of questions in the survey to get as much detail from the participants as possible.

Measures

The survey for this study included qualitative and quantitative questions. For the qualitative portion of this study, the survey asked a series of open-ended questions aimed at gaining an understanding of the survey participants' schools' trauma informed practices, behavior management strategies, and efforts taken to promote the success of their students with trauma. These questions are provided in the Figure 3.1. The few quantitative questions included in the survey were either multiple choice or Likert scale format. These questions aimed at gaining specific details, such as what grade levels the participant works with, whether their school is trauma informed, and how often suspension and expulsions are used as punishments for challenging behaviors. All survey questions are provided in Appendix C.

Table 3.1 Qualitative Survey Questions

Which Participants Responded	Survey Question
All	Please estimate the racial demographics of the students at your school, e.g. 50% white, 25% black, 10% Hispanic, 15% other.
	Please estimate the gender demographics of the students at your school, e.g. 50% male, 50% female.
	Please estimate the socioeconomic demographics of the students at your school, e.g. 25% under the poverty line, 50% middle class, 25% upper class
Those with Trauma Informed Care	Describe what trauma informed care looks like at your school?
	Where did these policies come from/who advocated for their implementation?
	When was trauma informed care implemented in your school?
	What do you think the benefits of these policies are?
	What was the process of implementation like?

Those Without	Has your school considered implementing trauma informed practices?
	What are the barriers preventing the implementation of trauma informed care?
Trauma Informed Care	What do you think could be done to break down these barriers?
All	If a child presents challenging behaviors, what is the typical staff response to attempt to manage those behaviors?
	What are the most common challenging behaviors students present?
	What is typically used as punishment for these behaviors?
	What support does your school give to teachers, administrators, and staff dealing with behavior problems?
	What types of trainings are provided for staff at your school?

Data Analysis

The data collected from the qualitative questions were analyzed using constant comparison analysis. Leech and Onwuegbuzie (2008) assert that constant comparison analysis can be used with all forms of qualitative research to enable the researcher to find themes in their data. This process began with the researcher compiling all participant responses and reading through them to become familiar with the data. The next step is open coding, which is conducted by the researcher grouping similar responses across the survey into categories (Leech and Onwuegbuzie, 2008). Next, axial coding is used by the researcher to group the categories into broader themes (Leech and Onwuegbuzie, 2008).

The quantitative data collected from the survey were analyzed in Microsoft Excel. Descriptive analyses were completed by examining the distribution of responses and reporting out representative percentages for the various demographic characteristics.

Chapter 4: Results

Surveys completed by 24 Master's level school social work students from Ohio State University about their field placements gained information about the schools' demographics and explored the three specific aims of this study: common elements of trauma informed care in schools, behavior management strategies and practices used in schools, and efforts taken by schools to promote the success of students with trauma histories.

Demographic Information

Of the 24 school social work students who completed the survey, 20 were completing their field education in a public school and 4 were placed in a charter school. 6 study participants reported that they work with elementary aged students, 6 worked with high school students, 2 worked with all grades, and the remaining worked with a combination of age ranges. 10 participants estimated the racial demographics of the students at their school to be over 75% white and 14 reported their school's demographics to be less than 75% white. 9 individuals estimated their school to have over 75% of its students be considered economically disadvantaged and 15 estimated that their school has less than 75% economically disadvantaged students.

Of the 13 schools which were reported to have trauma informed practices, 2 were estimated to have a student population that is predominately white, 4 were predominately of color, and 7 had a diverse student body with less than 75% of any one racial demographic, as seen in Figure 4.1. Of the 9 schools that are not trauma informed, 7 were predominately white, 1 was predominately black, and 1 had less than 75% of any one group, shown in Figure 4.2. Regarding socioeconomic status, schools with trauma informed care were about equally divided, with 6 schools estimated to have 75% or more of students being considered economically

disadvantaged and 7 schools with less than 75% of students being economically disadvantaged, demonstrated in Figure 4.3. For schools without trauma informed practices, 3 schools were reported to have a student population with 75% or more economically disadvantaged and 8 reported to not be predominately economically disadvantaged, as shown in Figure and 4.4.

Figure 4.1

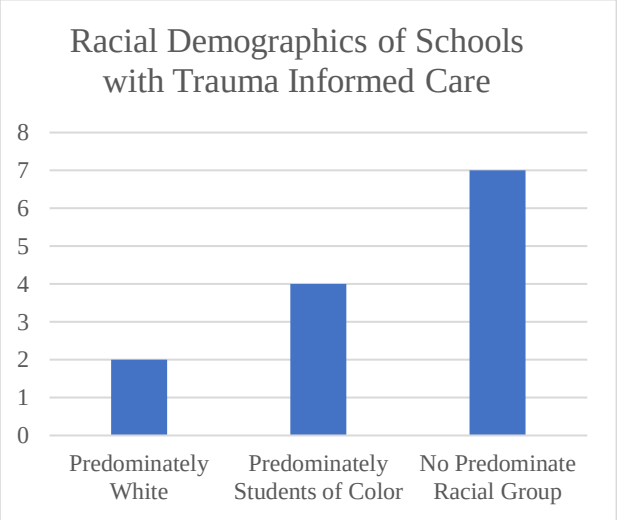


Figure 4.2

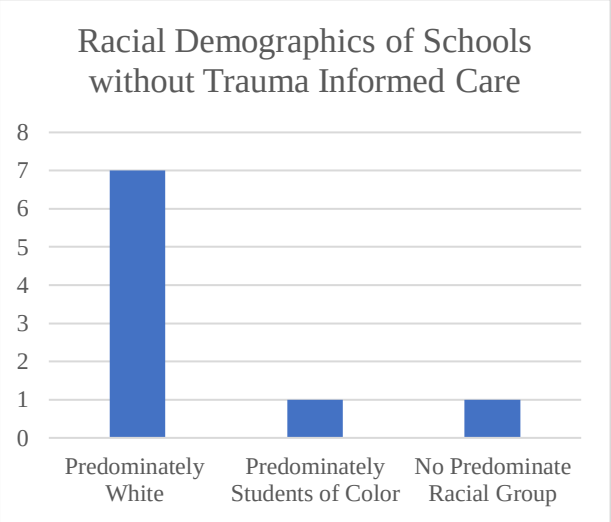


Figure 4.3

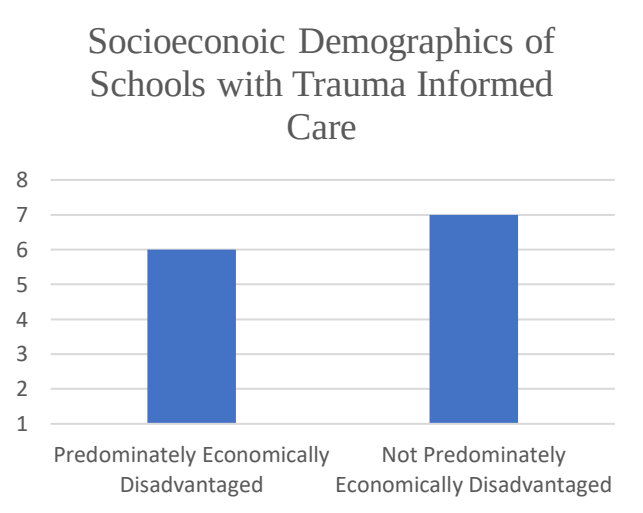
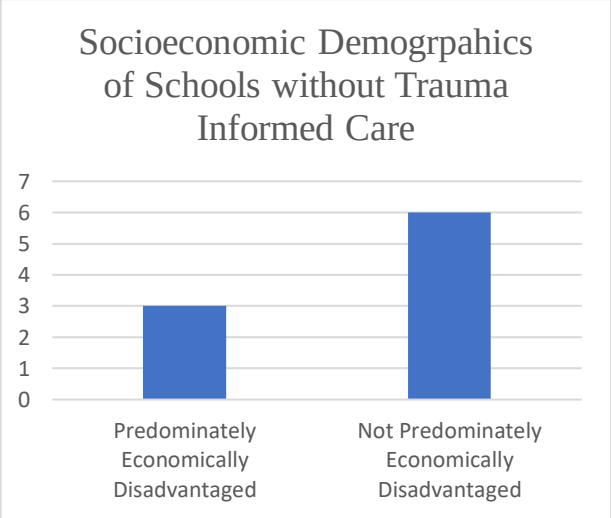


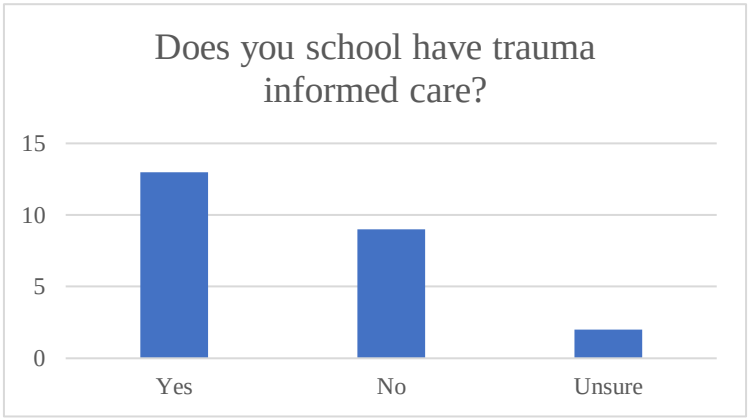
Figure 4.4



Elements of Trauma Informed Care

Of the 24 participants, 13 (54.2%) reported that their school currently practices trauma informed care, 9 (37.5%) reported that their school did not have trauma informed care, and 2 (8.3%) were unsure, as demonstrated in Figure 4.5. For participants who reported that their school had not implemented trauma informed care, 4 said their school had considered its implementation, 1 said their school had not considered it, and 4 were unsure. Survey participants who reported that their school is trauma informed were asked several questions relating to the types of trauma informed practices at their school. Each participant described these trauma informed practices differently, but from these varying responses, thematic coding was used to identify seven main elements of trauma informed care that were common across several of the schools represented in this survey. These common elements are the understanding that trauma contributes to behavioral issues, the use of specific trauma informed programs, referring students to a mental health professional, teacher and staff trainings, support from administration, crisis management staff, and students feeling emotionally supported.

Figure 4.5



Trauma Contributes to Behavior

Several of the participants who reported that their school is trauma informed reported that staff and teachers at their school have a general understanding that behavior is complex and that students' behavior problems may be the result of trauma. One participant described that their school's trauma informed care meant "teaching school personnel about seeing past problematic behaviors and what they really mean." Several participants mentioned that their practices aim to help "the whole child," with one participant describing their practices as "understanding behavior and complex contributing factors. Using interventions and programs that address the whole child in their environment." Several respondents also explained that their school focuses on students' trauma with one saying "most teachers consider the child's stressors before giving a punishment," and another expressing "my supervisor also does a great job of providing trauma-informed care and advocating for it for our students by listening to their lived experiences and focusing on what has happened to them, instead of asking 'what's wrong with you?'"

Specific Trauma Informed Programs

Some study participants mentioned that their schools utilize a specific trauma informed program or curriculum. The "PAX Good Behavior Game" was mentioned by two respondents as part of their trauma informed practices used in classrooms. Two participants also reported the use of Positive Behavior Interventions and Support (PBIS) in their school. Another respondent mentioned "There are two social workers in the building. Both are NME trained," referring to the Neurosequential Model in Education.

Referral to Mental Health Professional

Several participants expressed that one of their trauma informed practices is referring students to mental health professionals, such as school social workers, guidance counselors, or psychologists. Participants mentioned that school staff may refer students to in school services, such as with a school social worker, to outside mental health agencies, or to both. One participant identified that their school "utilizes school-based counseling service or refers to outside agencies for mental health care often."

Teacher and Staff Trainings

Many of the survey respondents reported that teacher and staff trainings have been a part of the trauma informed care at their school. Some participants reported trainings for teachers, with one describing that "teachers have received a number of trauma informed professional development over the past couple of years." Other respondents reported trainings for all school staff members, not just teachers. One participant explained that "all staff is trained in trauma informed care," while another reported "I know many if not all school staff have been to TIC trainings." When asked to rate on a Likert scale how much they agreed that their school provides opportunities for professional development and reflection, 9 of the 13 participants whose schools are trauma informed reported that they agreed or strongly agreed, while 6 of the 11 participants whose schools were not trauma informed or who were unsure reported the same.

Support from Administration

Another element common to many of the participants' descriptions of trauma informed care was support from the schools' administration. One participant said, while describing barriers to trauma informed care, that "there haven't been many barriers. Administrative team has been

supportive." Other participants specified that support from their schools' principal has been important to their trauma informed practices. One participant said about their trauma informed practices that "the principal is also very open to implementing these strategies with the students." Another described their trauma informed care includes that "the principal makes an appoint to make sure every child understands the reasons behind any punishments given." Administration support also includes the school districts, with one respondent saying their trauma informed "policies come from the district office where there is a team of individuals social workers, preschool principals, special education team members that advocate for these practices." Another participant included in their description of their trauma informed practices that "the school district has policy for gender non-conforming students and has annual presentations on working with this student population."

Crisis Management

An additional element of trauma informed care identified from the participants' responses was the importance of crisis management and the employment of specific crisis management staff members. One respondent reported that two aspects of their trauma informed practices are "crisis interventions… and crisis support teams." Another described that "we always have a 'hall duty' staff for kids who ask for breaks, need support, or are in crisis."

Students are Emotionally Supported

The last element of trauma informed care reported by the survey respondents was that students in their schools feel emotionally support by the staff. One participant expressed "I think students feel more supported and understood," and another reported that "the students feel heard, and validated in their concerns." Additionally, a respondent explained that trauma informed care

resulted in “a more inclusive school & a better environment for all students,” while another described that “children feel safer at school” because of trauma informed care. Lastly, one participant expressed that “being trauma informed and taking a calm approach helps staff build trust and rapport with the kids easier. It creates a culture where kids will come to us if something is wrong or if they need support because they feel safe and comfortable doing so.”

Behavior Management Strategies Used in Schools

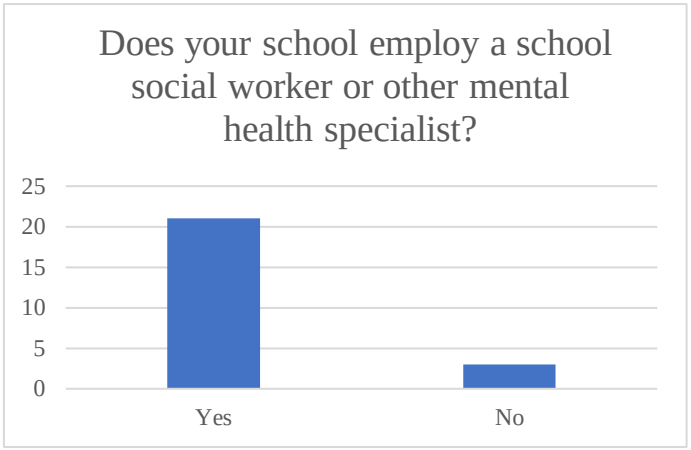
The next concept explored in this study is behavior management strategies and practices used in schools. 22 of the 24 participants reported that teachers at their school deal with challenging student behaviors often or very often. Participants were asked to answer questions about what happens following the occurrence of these types of behaviors and their responses fell into one of two themes; the school works with the student to solve behavioral issues and the student is punished for the behavior. It is important to note that these categories do not strictly align with trauma informed schools versus non-trauma informed schools. Participants who reported that their schools were trauma informed also reported that students are punished for behaviors and schools that reported they are not trauma informed also described that they work with the student to find solutions to behavioral issues.

School Works with Student to Solve Behavior Issues

Many survey participants reported that their school works with the student to solve behavior issues as their main behavior management strategy. One way that schools work with students is by referring them to mental health services, either in school or out of school with an outside mental health agency. One participant described that “when challenging behaviors do arise, students are often sent to the guidance office to talk and cool down.” Another explained

that “if behaviors are extreme, the school counselor or social worker will be called to classroom to remove the child from the classroom until under control.” Another described their school climate towards mental health services as “receiving mental health support is very open at my school.” 21 of the survey respondents (87.5%) reported that their school employs a social worker or other mental health specialist, with 3 (12.5%) reporting that their school does not, as shown in Figure 4.6.

Figure 4.6



Another way participants reported staff members work with students with behavioral issues is by talking with the student as the first step of behavior management. One participant described, “typically, staff tries to redirect the child in the classroom first to prevent a blow out or a crisis. Staff will ask the child what they need right now and how they can be helpful.” Another participant expressed the same concept by explaining “the typical staff response is to talk to them to see what is happening and if they need extra support.” In addition, another participant expressed that staff members will “talk with them and see what they are trying to communicate.”

Many participants expressed that their schools will give students breaks to calm down when they demonstrate a challenging behavior. One described that students "aren't punished but get 'brain breaks.' A quiet break to have a chance to calm down and learn to problem solve." Another explained that after staff ask a student with a challenging behavior what they need, "sometimes kids will respond by asking for a sensory tool/fidget/coping box or to take a regulation break, get a drink of water, walk laps in the hallway, etc." One participant reported that some students with continuing behavior issues "already have sensory breaks built into their day, and can access extra sensory breaks if they become upset." Some participants described dedicated rooms in their schools where students can go to calm down. Participants described "the SMART Lab (cool down space)," a "recharge station," and "rooms for students to take breaks or go on time out."

Some participants also explained that their schools' staff members will use positive reinforcement of desired behaviors to prevent challenging behaviors from occurring. One participant described that "generally teachers use positive reinforcement/ rewards to encourage better behavior." Another reported that "the school utilizes PBIS strategies, so staff focus is typically on those positive/pro-social behaviors."

The establishment of a behavior plan for a student with behavior issues was another way study participants reported that their schools works with students. One respondent described that "a behavior plan may be implemented after behaviors become ongoing." Another participant described that if positive reinforcement of desired behaviors is not successful, "usually a behavioral meeting will be held with teachers/parents/admin. to strategize how to best help student."

Study participants also reported that their schools may work with a student's family to solve their behavior issues. They reported that the school may call parents to inform them of their child's behavior, or they may be involved in meetings with school staff to establish a behavior plan. One respondent explained that "with anxiety related behaviors, we try to work with staff and parents to address them." Another participant described how their school works to connect the home and school; "Everything is documented through incident reports and parents are contacted. Clinicians work with families to establish different accountability plans at home for kids (no access to electronics, not going to the library/other places in community after school, no special treat/snack, point systems)."

Lastly, participants reported the use of restorative practices as a means of working with the student to solve behavioral problems. Respondents described that "we work on using restorative practices or referral to mental health for treatment if deemed necessary" and the use of "restorative circles." Additionally, one participant described their restorative practices as "sometimes kids will have to make amends with other students or staff they've hurt by their actions by making an apology letter or coloring a picture."

School Punishes the Student

The first way that survey participants reported students are punished for challenging behaviors at their schools is with detention, in-school suspension, or out of school suspension, depending on the severity of the behavior. One participant reported that "students with challenging behaviors are usually sent to the office, where they most frequently receive a detention or suspension from administrators." Another said, "fighting might be an ISS or OSS, depending on how often the student causes issues." Only one respondent mentioned that expulsion from school was a possible punishment, saying "removal from the school, suspension,

and expulsion for extreme case." When asked how often their school uses suspension and expulsion as a punishment, 15 participants reported that they are used rarely or never, 6 reported they are used sometimes, and 3 reported they are used often or very often. The 3 schools that use suspension and expulsion often or very often were reported to not have trauma informed practices.

Another way that schools punish students for their challenging behaviors is with the loss of recess or other privileges. Participants described that challenging behaviors may result in "missed recess time, detention, depends on the grade level," "owed recess time," and "missing recess." Another participant described that "students typically lose access to privileges like free time, recess, or classroom rewards." One respondent also explained that "students are given 'minors' which are disciplinary infractions that cause them to have less freedoms within the class."

Lastly, some study participants described witnessing negative teacher and staff responses to challenging behaviors, such as yelling and losing their temper. One participant described "depends on the staff member, I've seen some who talk to the student, some who simply yell at the student, some give into the student." Another respondent explained that "most teachers have reached burn out, so this results in the escape measures by teachers, telling the student to leave the class or going immediately to punishment. … and there are teachers who brag about bullying their students." When speaking of the school principal, one participant said, "he has the hardest time out of all the staff members that I have seen not losing his patience with students he tried to help get back to class." It is important to mention that the last two of these examples were given by participants who reported that their schools are trauma informed, showing that having trauma

informed practices does not necessarily mean that schools are doing their best to help the students who are dealing with trauma and its effects.

Promoting the Success and Wellbeing of Students with Trauma

The last topic explored in this study is the efforts that are taken by schools, regardless of whether they are trauma informed or not, to promote the success and wellbeing of students with trauma histories. The efforts included referrals to mental health services, strong and supportive relationships between staff and students, and preventing challenging behaviors before they happen. These efforts were mentioned by both participants who reported their schools are trauma informed and by participants who reported that their schools did not have trauma informed care.

Mental Health Services

Participants at both schools that are trauma informed and those are not often frequently reported referring students with behavioral issues that may have experienced trauma to a mental health professional. This was often reported as happening inside the school building as a referral to the school social worker or guidance counselor. One participant described, “when challenging behaviors do arise, students are often sent to the guidance office to talk and cool down.” Another explained that following a difficult behavior, “a child is referred by a teacher or the principal and a social worker intervenes.” Another mentions that interns may also be utilized as mental health workers, describing that “the staff will bring the student to the guidance counselor or the social work intern.”

Supportive Teacher-Student Relationships

Many participants described supportive teacher and student relationships at their school. This often looks like teachers having conversations with students when a challenging behavior

arises. As a first step of managing these behaviors, one participant describes that "the teacher tries to calm the student down" and another mentions that "they talk with them and see what they are trying to communicate." Another participant describes that teachers will try to "intervene" and "figure [behavioral issues] out" before taking any other disciplinary or referral actions.

Preventing Behaviors Before They Happen

Lastly several participants mentioned that teachers and staff aim to prevent behavior problems before they happen. Some participants mentioned the use of behavioral planning to prevent future behaviors, with one stating "a behavior plan may be implemented after behaviors become ongoing." Other participants describe the use of breaks to allow students to calm down if they are getting worked up, with one participant mentioning that they "utilize rooms for students to take breaks or go on timeout." Another participant explained that "some students already have sensory breaks built into their day, and can access extra sensory breaks if they become upset." Also, respondents described using positive reinforcement of desired behaviors, with one stating that the "staff focus is typically on those positive/pro-social behaviors."

Chapter 5: Discussion

Summary of the Results

From this study, it was found that 54% of school social work students reported that the school in which they are completing their field placement has trauma informed care, 38% reported that they did not have trauma informed practices, and 8% were unsure. The sample was mostly comprised of students placed in public schools (83%) and schools working with all age ranges of students were represented. Participants were asked to estimate the racial demographics of their schools, and it was found that schools with trauma informed care were more likely to have no predominate racial group, whereas schools without trauma informed care were more likely to be predominately white. Participants also estimated the socioeconomic demographics of their schools. It was found that while schools with trauma informed care were about equally likely to be economically disadvantaged and not economically disadvantaged, schools without trauma informed care were more likely to not have a predominately low-income student population.

Survey respondents who reported that their schools are trauma informed were asked to describe these practices, and their responses greatly varied. These qualitative data were analyzed to find common elements of trauma informed care used by these schools. These common practices include the understanding that trauma contributes to behavioral issues, the use of specific trauma informed programs, referring students to a mental health professional, teacher and staff trainings, support from administration, crisis management staff, and students feeling emotionally supported.

All survey participants were asked several questions about the strategies their schools use to manage difficult behaviors. These behavior management strategies reported in the survey were

analyzed and grouped into two themes, the school works with the student to help solve their behavioral issues, and the school punishes the student for their behavior. These themes were present in the descriptions of practices from schools that were both trauma informed and not trauma informed.

This study also found the common efforts taken by schools, regardless of whether they are trauma informed or not, to promote the success and wellbeing of students with challenging behaviors who may have experienced trauma. These efforts include referrals to mental health services, strong and supportive relationships between staff and students, and preventing challenging behaviors before they happen.

Explanation of the Meaning of the Results

Demographic results

The racial and socioeconomic demographic differences reported between schools with and without trauma informed care are likely related to the racial and socioeconomic disparities of childhood trauma. It has been shown in the literature that certain populations of youth, including youth of color and youth that are economically disadvantaged, are more likely than the general population to experience trauma (Lawrence & Hesse, 2010). Considering that youth of color and youth that are economically disadvantaged are statistically more likely to experience trauma, it makes sense that schools with a student population that is predominately white or upper class will be less likely to implement trauma informed care. These schools may make the assumption that their students are less needing of trauma informed care because their students are less likely than marginalized populations to experience a traumatic event.

Although the research shows that youth of color and youth of lower socioeconomic status are at a higher risk for experiencing trauma, it would be inappropriate of schools with a higher

population of white and middle to upper class students to assume that trauma informed care is not needed at their school. The research suggests that as many as 80 percent of all youth experience at least one traumatic event before adulthood, and childhood trauma can affect youth of all races, ethnicities, and socioeconomic status (Turner, Finkelhor, & Ormrod, 2010). A traumatic event can be any experience that is perceived as physically or psychologically harmful and affects a child's functioning (SAMHSA, 2014). This definition of trauma allows for any number of experiences, including illnesses, car crashes, natural disasters, and many others, to be considered traumatic. These types of experiences can affect anyone, regardless of their racial and socioeconomic identity.

Common Elements of Trauma Informed Care

This study found several common elements of trauma informed care that were reported to be used by schools represented in this study. The practices that were reported by participants varied and were described using different language. This demonstrates the lack of standardization of trauma informed educational practices. There are no standardized practices for schools to implement, resulting in vastly differing practices among schools. This means schools approach students with trauma differently, and these students are receiving a different quality of care depending on the school they attend.

From the varied responses reported by participants, seven common elements of trauma informed care were identified. This signifies that while each trauma informed school has different practices, there are some commonalities between many of the schools. These common practices can serve as a guideline for schools wishing to implement trauma informed practices.

Very few of the trauma informed practices described in the survey data were based on evidence-based trauma informed programs or curricula. The majority of the trauma informed

methods used by these schools were comprised of several practices assembled together, rather than using a dedicated trauma informed curriculum. This is meaningful because without the use of an evidence-based curriculum, schools may not be doing all that can be done to help students with trauma. An evidence-based curriculum is demonstrated to be effective and when used, schools can know that they are providing the best level of care for their students.

Behavior Management

This study established two themes of behavior management strategies reported by survey participants, schools work with the student to solve behavior problems or they punish the student for the behavior. These themes are not unexpected, as they are traditionally the ways that behavioral problems are dealt with in schools.

These two themes are not separated evenly between schools that are trauma informed and those that are not, as one may expect. Participants who reported having trauma informed care at their schools also reported the use of punishments, and schools that are not trauma informed reported working with the student to find solutions to behavioral issues. This indicates that schools that report that they are trauma informed may still engage in practices that are not necessarily trauma informed or beneficial to their students with trauma, like suspensions and expulsions. These exclusionary disciplinary practices are not beneficial to youth with trauma, as they are forced to experience a disruption in their routine and are not allowed to attend school, which may be a safe place for them or may be the only refuge they have from their trauma experience (Coleman, 2009). The evidence found by this study of these exclusionary practices in schools that are trauma informed signifies that these schools can still make changes to better help their students. Just because a school says it is trauma informed, does not mean that they are

doing what is best for their students with trauma histories. Schools should always be evaluating and reflecting on what they do for their students in order to identify what they can improve.

In addition, many schools represented in the study reported the use of practices that fall into both themes. For example, one participant reported that in response to a challenging behavior, a student may be given "a quiet break to have a chance to calm down and learn to problem solve. If it's really bad then they could have their parents get called or they can be suspended." This shows that even when schools use exclusionary punishments, the first step may be an attempt to work with the student to solve the issue. This displays that a school's behavior management strategies may be nuanced and even schools that are not trauma informed are taking some steps to help students with trauma related behavioral issues be successful.

Efforts to Promote Success and Wellbeing of Students with Trauma

Lastly, this study found three common efforts that were seen across many of the schools, both with and without trauma informed care, to promote the success and wellbeing of students who may have experienced trauma. The identification of these efforts across many of the represented schools signifies that many schools, even those that are not trauma informed, are making an effort to support students with trauma. This is important because it shows that even schools that don't have trauma informed care are making an effort to help students with trauma, and these students are receiving some amount of support from their schools.

Implications

This study has several implications for practice in the fields of school social work and education. One of the main functions of this study is to show how trauma informed care is being used in schools and by school social workers. The findings of this study provide a basic outline of the practices that trauma informed schools are using to help students improve trauma related

behaviors, academic performance, and overall well-being. These findings give a general guideline of trauma informed practices that can be implemented by schools and school social workers. School social workers or other professionals could implement one or more of these strategies into their own practice in order to better help their students who have trauma histories.

This study also examines the behavioral management strategies used in schools with and without trauma informed care. It was found that schools with trauma informed care also report the use of punishments for student behavioral issues, including suspensions and expulsions. This means that trauma informed schools could be doing even more to help their students with trauma and should continue to evaluate and improve their practices.

Some schools that reported trauma informed care also reported negative teacher responses to student behaviors and high rates of burn out. Burnout is a prevalent issue in helping professions that can impact the quality of care that professions provide (Wilson, 2016). One participant who reported their school is trauma informed reported that "most teachers have reached burn out, so this results in the escape measures by teachers, telling the student to leave the class or going immediately to punishment." These professionals should reflect on the quality of services they are providing to their students and if their actions and judgement are being affected by burnout or high levels of stress.

This study also found three efforts taken to promote the success and wellbeing of students with trauma that were reported by many participants regardless of whether their school is trauma informed. These are practices that can be implemented into any school by any staff member who wants to give more support to youth who have experienced a traumatic event.

This study also has implications for public policy. One of the main findings of this study is that trauma informed care varies across schools and school districts. It is not standardized and

there is no requirement for what trauma informed practices should include. Every school approaches students with trauma differently and these students receive different treatment at every school. It would be beneficial for children who have experienced trauma for there to be standardized guidelines of trauma informed care at all schools. These youth with trauma would be better served and would experience better outcomes, no matter where they go to school.

Limitations

This study had several limitations. First, it had a small sample size of 24 participants. These participants were recruited through the College of Social Work Office of Field Education at Ohio State University, and likely completed the survey about a school in the central Ohio area, although location data was not collected. It is also unknown what type of geographic area the schools are located in, as data was not collected about if the school is in a rural, suburban, or urban area. As a result of these limitations, the findings from the data obtained from these 24 participants are not generalizable across all schools.

In addition, the participants of this study were school social work interns, and as such, the data gathered from this study was reported to the best of these students' knowledge. Some of these students may have had incomplete knowledge about the practices at their school and may have unknowingly misreported some data, as the school social work curriculum requires that they attend their field placement for only 24 hours a week. Future research should collect data from full time school employees who would presumably have more knowledge about school practices and may have had a role in the implementation of those practices.

It is also possible that the participants may have been unaware of school wide practices because they only have experience working in the social work department. For example, one participant explained about students with challenging behaviors, that "due to the communication

struggle, I do not know the follow-up that happens with these cases," but was able to describe what they assumed happened as a disciplinary measure for these students. Future research should involve participants from all departments and professions within schools in order to capture accurate depictions of school wide practices and the full experiences of students with trauma in that given school.

Additionally, at least two participants reported that their schools are not trauma informed but described practices that would be considered trauma informed. This suggests that some data may have been misreported or that the participants did not have a clear definition of trauma informed care. It may have been beneficial to have provided participants with a brief definition and description of trauma informed care to ensure that they understood what the survey was asking.

Lastly, there were some issues with the survey questions that are limitations for this study. The questions for this survey were intentionally left vague and open-ended, however more information could have been gained through asking more specific detail-oriented questions. For example, it would have been beneficial to ask participants about their schools' practices from certain levels or positions, such as asking what specific trauma informed actions are taken by the school social worker or principal. This would have produced a clearer picture of a school's trauma informed practices and what professions are involved in these practices. In addition, it may be a limitation that only participants who reported that their school has trauma informed care were directly asked about what they do to help students with trauma. Some participants indicated that they did not have trauma informed care, but went on to describe somewhat trauma informed practices, and it may have been beneficial to this research effort to have collected more data about the practices in these schools, not just those that reported they were trauma informed.

Future Research Recommendations

This study contributes to the scientific literature regarding trauma informed care and provides information about the common elements of trauma informed care used in schools. It also provides a basis of understanding about the types of behavior management strategies that are used in schools and the efforts that schools take to promote the success and wellbeing of students who have experienced trauma. Going forward, further research is needed on this topic in order to gain a full understanding about how trauma informed care is utilized in the educational system and what trauma informed practices are commonly used in schools. Expanding upon this research will allow for researchers to discover the specific ways schools are helping students with trauma histories and the rates at which schools use specific trauma informed practices. Further research should also be done to establish evidence-based trauma informed practices that can be standardized across all schools to ensure that all students who have experienced trauma can receive the support they need.

Chapter 6: Conclusion

This study was intended to fill a gap in the existing literature about the common types of trauma informed practices that are implemented in schools and how often they are used. This study accomplished filling this gap through the use of an online qualitative survey sent to Ohio State school social work students. These surveys collected data about the school where the students were completing their field education component of their degree. The survey asked questions about the schools' trauma informed practices and behavior management strategies. From the data collected in these surveys, several common types of trauma informed practices were found, as well as two themes of behavior management strategies, and three practices that schools take to promote the wellbeing of their students with trauma. This study contributes to the scientific literature about the use of trauma informed care in educational settings and has implications on practice, policy, and future research efforts.

This study was necessary because the gap in the literature results in an inaccurate picture of how and how often schools are helping students who have experienced trauma to overcome their challenges and be successful in and out of school. Researchers having access to this knowledge allows for them to investigate the best practices for engaging and intervening with youth who have experienced trauma in a school setting. These youth with trauma need and deserve to have the best available services provided to them, and this study provides a step in that direction.

This study and its findings are significant because childhood trauma is a prevalent and impactful issue in our society. Schools are the ideal setting for this type of trauma to be addressed, and educational professionals should take steps to support their students who have experienced trauma and help them to be successful. The findings of this study contribute to the

literature about trauma informed schools and move research towards understanding how schools help students with trauma and identifying the best practices for schools to help these students overcome their challenges and have better outcomes.

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Survey Questions

1. What is your role at your field placement?
    - Select
        - school social work intern
        - after school program social work intern
        - other
2. Is your school
    - Select
        - Public
        - Private
        - Charter
        - Other
3. What grades of students do you work with?
    - Select all that apply
        - Kindergarten
        - 1st
        - 2nd
        - 3rd
        - 4th
        - 5th
        - 6th
        - 7th
        - 8th
        - 9th
        - 10th
        - 11th
        - 12th
        - Other
4. Please estimate the racial demographics of the students at your school, e.g. 50% white, 25% black, 10% Hispanic, 15% other.
5. Please estimate the gender demographics of the students at your school, e.g. 50% male, 50% female.
6. Please estimate the socioeconomic demographics of the students at your school, e.g. 25% under the poverty line, 50% middle class, 25% upper class.
7. Does your school have trauma informed policies?

If yes on #7:

8. Describe what trauma informed care looks like at your school?
9. Where did these policies come from/who advocated for their implementation?
10. When was trauma informed care implemented in your school?
11. What do you think the benefits of these policies are?
12. What was the process of implementation like?

If no on #7:

13. Has your school considered implementing trauma informed practices?
14. What are the barriers preventing the implementation of trauma informed care?
15. What do you think could be done to break down these barriers?

All participants:

16. If a child presents challenging behaviors, what is the typical staff response to attempt to manage those behaviors?
17. What are the most common challenging behaviors students present?
18. How often do staff deal with these behaviors?
    - Very often
    - Often
    - Sometimes
    - Rarely
    - Never
19. What is typically used as punishment for these behaviors?
20. How often is suspension or expulsion used to manage students' challenging behaviors?
    - Very often
    - Often
    - Sometimes
    - Rarely
    - Never
21. What support does your school give to teachers, administrators, and staff dealing with behavior problems?
22. What types of trainings are provided for staff at your school?
23. There are opportunities for staff reflection and professional development provided by your school.
    - Strongly agree
    - Agree
    - Somewhat agree
    - Neither agree nor disagree
    - Somewhat disagree
    - Disagree
    - Strongly disagree
24. Does your school employ a social worker or other mental health specialist?